MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09574

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 7 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Hopkinsville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	EDWARD	ANDERSON	October	13	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	July 12, 1929	20 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Furniture Store	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Sheridan Anderson	Josephine Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.	215-26-1537	Mrs Josephine Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Fractured Skull	45 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Automobile accident.	
(c)		

813.5
170C

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	Route 32	Sykesville	Howard	Md

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☒	HOW DID INJURY OCCUR?
October 13 1949 6:00 p.m.		Truck struck the man who was riding bicycle

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James I. Wood	Deputy Medical Examiner	Westminster Md	October 13-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 16 1949	Springfield	Sykesville, Carroll, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 15, 1949	C. Harry Weer	C. H. Weer	Sykesville, Md.

VS. A15A

RECEIVED
OCT 19 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

PC 09575

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 wks

Hospital, institution, or street address where death occurred: RD #5 Westminster Md.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1419 Dukeland St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mary Helen Ball

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: J. E. Raymond Ball.

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Feb 13 1889

8. AGE: Years	Months	Days	If less than one day
60	8	10	...hrs. ...min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER — 12. Name: John T. Burke

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Eliza Foldkemer

15. Birthplace: Shrewsbery, Pa.

16. Informant: J. E. Raymond Ball

Address: Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/26/49 (month) (day) (year)

Cemetery or crematory: Meadowridge Cem.

Location: Howard Co., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 10/24 19 49 (Date rec'd by registrar) D. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 19 49, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 18 19 49 to Oct 23 19 49

and that I last saw h... or alive on Oct 18 19 49

	DURATION
Immediate cause of death: Cerebral hemorrhage.	7 wks
Due to: Hypertension.	3 yrs
Due to: 331	
Other conditions: 83a	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Julius Chepko, M. D. M. D. or other

Address: Westminster Md. Date signed Oct 23, 1949

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09576

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Uniontown Rural
LENGTH OF STAY (in this place): 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Uniontown Rural
STREET ADDRESS (If rural, give location): near Uniontown

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Edgar	G	Barnes	Oct	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Sept 20-1898	51 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Salesman	Maryland	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
J Edgar Barnes	Leah Ensor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	216-05-1664	Vivian Englar Barnes

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis with Hypertension	several years
260 61	(c) Diabetes Mellitus (mild)	several yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Oct 18, 1949, to Oct 20, 1949, that I last saw the deceased alive on Oct 20, 1949, and that death occurred at 8.05 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T Marsh	M.D	Westminster Md	Oct 21 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 22-49	Pipe Creek Cemetery	New Windsor Road	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct 21, 1949	Margaret K. Englar	D.D. Hartsler & Sons	New Windsor & Union Bridge, Md

RECEIVED
NOV 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09577

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll County
City or town: Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? — 4 months —
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County:
City or town: Gettysburg, Pa
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Gertrued C Becker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: John David Becker Sr.
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): March 21 - 1898

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
51	6	10		

9. Birthplace: Pa. (Town, county, and state)
10. Usual occupation: Housewife —
11. Industry or business:

FATHER
12. Name: William C. Shull
13. Birthplace: Penna.

MOTHER
14. Maiden name: Sarah Ann Jacobs
15. Birthplace: Penna.

16. Informant: Sara A. Lambert
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-6-49 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Jacob Winter Sons
Address: Manchester Md

19. Oct 4 1949 (Date rec'd by registrar) Mrs. M. R. S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 1 - 1949 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1949 to Oct 1949 and that I last saw her alive on Sept 28 1949

Immediate cause of death	DURATION
Hypertensive arteriosclerotic Cardio-Vascular disease	4 ?
Due to Arteriosclerotic nephritis with uremia	2 yrs ?
Due to Anemia —	8 MON
Other conditions Congestive Heart Failure	3 MON

(Include pregnancy within 3 months of death)

442
Major findings of operations:
1310
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. H. Foard M.D. M. D. or other
Address: Manchester, Md Date signed Oct 2-1949

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09578

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) 14 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 610 Shriver Ave.

3. NAME OF DECEASED (Type or Print): (First) Verna (Middle) Salona (Last) Bill

4. DATE OF DEATH: (Month) October (Day) 30, (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 6-28-1893

9. AGE last birthday: 56 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Bill

14. MOTHER'S MAIDEN NAME: Mary Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral hemorrhage — about 5 hours

443 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive cardiovascular disease — about 11 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with mental deficiency — about 14 years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-2-42, 19..., to 10-30-, 19.49., that I last saw the deceased alive on 10-30-, 19.49., and that death occurred at 10.40 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Irene L. Hehmeyer, M.D. Springfield State Hospital 10-30-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: Nov. 2 1949 | NAME OF CEMETERY OR CREMATORY: Lonaconing | LOCATION (City, town, or county) (State): Lonaconing Md.

DATE REC'D BY LOCAL REG.: Oct. 31, 1949 | REGISTRAR'S SIGNATURE: C. Harry Keen | 24. FUNERAL DIRECTOR: C. H. Keen | ADDRESS: Sykesville Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09579

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster — LENGTH OF STAY (in this place): years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rural	STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print): (First) CHESTER (Middle) LEE (Last) BOONE

4. DATE OF DEATH: (Month) October (Day) 21 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 24-1898

9. AGE last birthday: 50 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Frederick County, Md

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Boone

14. MOTHER'S MAIDEN NAME: Carrie Wolfe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service): No.

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Hannah Mae Boone

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage	20 min
331 Antecedent cause(s)		
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis c̄ hypertension	4+ yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1946, to Oct 21, 1949, that I last saw the deceased alive on Oct. 16, 1949, and that death occurred at 9:30P m., from the causes and on the date stated above.

SIGNATURE: James T Thorsh (Degree or title): M.D. ADDRESS: Westminster Md DATE SIGNED: Oct 22/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Oct 24-1949 — NAME OF CEMETERY OR CREMATORY: Pipe Creek Cemetery — LOCATION (City, town, or county): Uniontown Road (State): Md

DATE REC'D BY LOCAL REG.: 10/24/49 — REGISTRAR'S SIGNATURE: L. Moodman

24. FUNERAL DIRECTOR: D.D. Hartzler & Sons — ADDRESS: New Windsor & Union Bridge, Md

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 28 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH BC 09580

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 1 mo. 20 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 17
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 1617 Argyle Avenue ✓

3. NAME OF DECEASED (Type or Print)	(First) LEE	(Middle) LONIELEE	(Last) BOOZE	4. DATE OF DEATH	(Month) Oct.	(Day) 8	(Year) 1949
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 22, 1910	9. AGE last birthday 39 yrs.	If under 1 year Months. Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Blackstone, Virginia	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Carter Booze	14. MOTHER'S MAIDEN NAME Agnes Cousins						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 230-12-2997	17. INFORMANT Deceased					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Feb. 1949
002 Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 17, 1949, to Oct. 8, 1949, that I last saw the deceased alive on Oct. 8, 1949, and that death occurred at 7:05 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Maryland Va.	10/8/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 10/12/49	NAME OF CEMETERY OR CREMATORY Blackstone Cem.	LOCATION (City, town, or county) Blackstone (State) Va.
DATE REC'D BY LOCAL REG. 10/8/49	REGISTRAR'S SIGNATURE Albert R. Swankhouse	24. FUNERAL DIRECTOR Joseph Russ	ADDRESS 1200 McCulloh St Balto. Md.

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 12 1949
BUREAU V. S.

09581

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 82

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Airy | LENGTH OF STAY (In this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Airy
STREET ADDRESS (If rural, give location) Main St.

3. NAME OF DECEASED (Type or Print): (First) ALBERT (Middle) N. (Last) BUCKINGHAM
4. DATE OF DEATH: (Month) OCT. (Day) 22 (Year) 1949

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 3-7-1879
9. AGE last birthday: 70 yrs. | If under 1 year: Months. Days. | If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: B.& O. R.R.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: B. W. Buckingham
14. MOTHER'S MAIDEN NAME: Virginia Bostian

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Bessie C.Buckingham, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uremia	1 mo
Antecedent cause(s) 331	(b) Cerebral Hemorrhage	over a two yrs. period
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 83a	(c) Arterio - Sclerotic Hypertension	5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1947, to Oct 22, 1949, that I last saw the deceased alive on Oct 21, 1949, and that death occurred at 6:40 p.m., from the causes and on the date stated above.

SIGNATURE Stanley Grabill (Degree or title) M.D. ADDRESS Mt Airy - Md DATE SIGNED 10/23/49

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | DATE: 10-25-1949 | NAME OF CEMETERY OR CREMATORY: PINE GROVE | LOCATION (City, town, or county) (State): Mt. Airy, Md.

DATE REC'D BY LOCAL REG. Oct. 25/49 | REGISTRAR'S SIGNATURE Thos D Snyder

24. FUNERAL DIRECTOR: C. M. Waltz, Winfield, Md. ADDRESS

RECEIVED
OCT 27 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09582

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Rural
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville Rural
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Donald (Middle) Franklin (Last) Bynaker

4. DATE OF DEATH: (Month) Oct. (Day) 10 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: July 14 1949

9. AGE last birthday: yrs. If under 1 year: Months 2 Days 26 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Philip Bynaker

14. MOTHER'S MAIDEN NAME: Catherine Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Philip Bynaker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bilateral Lobar pneumonia	1 day.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) acute entero-colitis due to diet.	3 wks.
	(c)	

571.0
119a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1, 1949, to 10-10, 1949, that I last saw the deceased alive on 10-10, 1949 and that death occurred at 5-30A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

S.H. Lawson - M.D. Sykesville Md 10-10-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Oct 12 1949 | NAME OF CEMETERY OR CREMATORY: Springfield | LOCATION (City, town, or county) (State): Sykesville Md.

DATE REC'D BY LOCAL REG.: Oct. 11, 1949 | REGISTRAR'S SIGNATURE: C. Harry Keen

24. FUNERAL DIRECTOR: C.H. Keen ADDRESS: Sykesville, Md.

RECEIVED
OCT 10 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH BC

2411 N. Charles Street, Baltimore

09583

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY CARROLL MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural- Sykesville; LENGTH OF STAY (in this place) 6 months, 23 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural give location) 307 South Sharp Street, Baltimore

3. NAME OF DECEASED (Type or Print)	(First) LEMUEL	(Middle) VIRGINUES	(Last) BYRUM	4. DATE OF DEATH	(Month) 10	(Day) 13	(Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 7/27/09	9. AGE last birthday 40 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Norfolk, Virginia	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME James L. Byrum	14. MOTHER'S MAIDEN NAME Betty Copland						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Record, Springfield State Hospital					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	known since ~~indefinite~~ 5-6-49
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

002

13b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic alcoholism with psychosis, D.T's. indefinite

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5/6, 1949, to 10/13, 1949, that I last saw the deceased alive on 10/13, 1949, and that death occurred at 2:40 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
M. Virginia Beyer	M. D.	Sykesville, Maryland	10/13/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 10/15/49	NAME OF CEMETERY OR CREMATORY Moreland Memorial	LOCATION (City, town, or county) (State) Taylor Avenue
DATE REC'D BY LOCAL REG. 10-14-49	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Mildred T. Blight, 6009 Harford Rd	ADDRESS

(44)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

09584

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) 7 years, 5 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Home for the Aged of the M.E. Church~~ Baltimore
STREET ADDRESS (If rural give location) ~~Baltimore Ave, Mt. Washington, Md.~~ 2211 Rogers Ave, Gospel Mission

3. NAME OF DECEASED (Type or Print): (First) Lilly (Middle) (Last) Cassell
4. DATE OF DEATH: (Month) October (Day) 7, (Year) 1949

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 5-9-1851
9. AGE last birthday: 98 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Cassell
14. MOTHER'S MAIDEN NAME: Mary Ing

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Methodist Home for the Aged-2211 W. Rogers Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic myocarditis and myocardial degeneration — years

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Generalized arteriosclerosis — over 20 years
(c)

1422.1 93d

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: Senile psychosis — known — 17 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-12-, 1943, to 10-6, 1949, that I last saw the deceased alive on 10-6-, 1949, and that death occurred at 5.15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Irene R. Wiekman, M.D — Springfield State Hospital — 10-7-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 10/10/49 — NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem. — LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG.: October 8th 1949 — REGISTRAR'S SIGNATURE: R.W.

24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

MARYLAND STATE DEPARTMENT OF HEALTH Pol 09585

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton | LENGTH OF STAY (in this place) 9 Mos. 17 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State San.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore-2
STREET ADDRESS (If rural, give location) 1032 Hillen Street ✓

3. NAME OF DECEASED (Type or Print): (First) CLARENCE (Middle) (Last) CHILDS
4. DATE OF DEATH: (Month) October (Day) 28 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: June 25, 1885
9. AGE last birthday: 64 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Jacksonville, Florida
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Clarence Childs
14. MOTHER'S MAIDEN NAME: Nancy (unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — May, 1948

Antecedent cause(s)

002 .13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 11, 1949, to Oct. 28, 1949, that I last saw the deceased alive on Oct. 28, 1949, and that death occurred at 12:50 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Reuben Hoffman, M.D. ADDRESS Henryton, Md. DATE SIGNED 10-28-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Oct 31st/49 | NAME OF CEMETERY OR CREMATORY Mt Calvary | LOCATION (City, town, or county) (State) Brookland Md.

DATE REC'D BY LOCAL REG. 10-28-49 | REGISTRAR'S SIGNATURE Albert R. Grantham Deputy Local | 24. FUNERAL DIRECTOR Elroy O Wilson | ADDRESS 1000 Brantley Av

VS. A15

RECEIVED
OCT 2 1949
U. S. DEPT. OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH

09586

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

I

T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) since 10/30/37	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural give location) ---

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph	---	CYMS	October	5	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Jan. 6, 1869	80 yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer	---	Germany	United States

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Paul Cyms	Annie Tremanofaky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
unknown	unknown	unknown	Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic myocarditis and myocardial degeneration.	about 10 months.
422.1 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	more than 12 years.
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Paranoid condition	more than 12years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
---	---	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
p ---	---	---		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
---			m.		---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Oct. 5, 1949, that I last saw the deceased alive on Oct. 5th, 1949, and that death occurred at 9:50 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin Gross M.D.	Martin Gross, M. D.	Sykesville, Maryland	10/5/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct. 7 1949	Springfield	Sykesville	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 6, 1949	C. Haney Keen	C. H. Keen	Sykesville, Md.

RECEIVED
OCT 11 1949
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH BC 09587

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville Md. — LENGTH OF STAY (in this place): 2 mths, 16 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore Md. -18
STREET ADDRESS (If rural, give location): 2007 E. 30th Str.

3. NAME OF DECEASED (Type or Print): (First) Nannie (Middle) (NANNIE DRAPER) (Last) Draper
4. DATE OF DEATH: (Month) Oct. (Day) 8 (Year) 1949
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 6-27-76
9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Talbot Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James Draper
14. MOTHER'S MAIDEN NAME: Annie Jenkins XXXXXXX
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT AND ADDRESS: NannieM. Carter. 2007 E. 30th St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary heart disease — 2 weeks

420.1 Antecedent cause(s) (b) Mitral insufficiency, arteriosclerosis — many years

48b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of uterus

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-22, 1949, to 10-8, 1949, that I last saw the deceased alive on 10-8, 1949, and that death occurred at 5.15 P m., from the causes and on the date stated above.

SIGNATURE: The Kamm — (Degree or title): M.D. — ADDRESS: Sykesville Md. — DATE SIGNED: 10-8-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Oct. 12, 49 — NAME OF CEMETERY OR CREMATORY: Meadowridge Park — LOCATION (City, town, or county) (State): Dorsey Md.

DATE REC'D BY LOCAL REG.: 10-10-49 — REGISTRAR'S SIGNATURE:
24. FUNERAL DIRECTOR: Henry Sander & Sons — ADDRESS: Baltimore Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09588

Reg. Dist. No. 83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Woodbine
LENGTH OF STAY (In this place): 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Woodbine
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) G. (Last) GRIMES

4. DATE OF DEATH: (Month) Oct. (Day) 10, (Year) 19 49

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWER, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 2-15-1862

9. AGE last birthday: 87 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer-retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: Basil T. Grimes

14. MOTHER'S MAIDEN NAME: Elizabeth Fleming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Grover Harrison, Woodbine, Md,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592 Immediate cause (a) Uremia (Chronic) — Interval between onset and death: 3 yrs

Antecedent cause(s)

1310 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Interstitial Nephritis — ? yrs

(c) Senility — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1924, 19..., to Oct. 10, 1949, that I last saw the deceased alive on Oct. 9, 1949, and that death occurred at 1:40 A. m., from the causes and on the date stated above.

SIGNATURE: J. Stanley Grabill — (Degree or title): M. D. — ADDRESS: Mt. Airy, Maryland — DATE SIGNED: 10/10/49

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: 10-13-1949 — NAME OF CEMETERY OR CREMATORY: Morgan Chapel — LOCATION (City, town, or county) (State): Woodbine, Carroll Co. Md.

DATE REC'D BY LOCAL REG.: Oct 11 49 — REGISTRAR'S SIGNATURE: Ina M Hewitt

24. FUNERAL DIRECTOR: C. M. Waltz, Winfield, Md. ADDRESS

RECEIVED
OCT 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09589

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville; LENGTH OF STAY (in this place) 10 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY Md; STATE 00; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Clara (Middle) Emma (Last) Hess

4. DATE OF DEATH: (Month) Oct (Day) 16th (Year) 1949

5. SEX F; 6. COLOR OR RACE W; 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed; 8. DATE OF BIRTH Sept 12-86; 9. AGE last birthday 88 yrs. If under 1 year: Months 2, Days, If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife; 10b. KIND OF BUSINESS OR INDUSTRY —; 11. BIRTHPLACE (State or foreign country) Unknown; 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Baker; 14. MOTHER'S MAIDEN NAME Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service); 16. SOCIAL SECURITY NO. none; 17. INFORMANT Mrs Lue L Rife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic Myocarditis	10 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Gen Arterio Sclerosis	1 yrs
	(c) Hypertension	0 "

443
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION; 19b. MAJOR FINDINGS OF OPERATION; 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify); PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY; (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.; INJURY OCCURRED While at Work ☐ Not While At Work ☐; HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 22, 1945, to Oct 15, 1949, that I last saw the deceased alive on Oct 15, 1949, and that death occurred at 4-45 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) H F Martin M.D.; ADDRESS Sykesville Md; DATE SIGNED Oct 15-1949

23. BURIAL, CREMATION, REMOVAL (Specify) Removal; DATE THEREOF 10/16/49; NAME OF CEMETERY OR CREMATORY; LOCATION (City, town, or county) (State) Frederick, Md.

DATE REC'D BY LOCAL REG. Oct. 16, 1949; REGISTRAR'S SIGNATURE C. Harry Weers

24. FUNERAL DIRECTOR; ADDRESS M. L. Eshelman & Son Frederick, Md.

RECEIVED
OCT 19 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09590

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Union Bridge — LENGTH OF STAY (in this place): 20 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: —

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Union Bridge
STREET ADDRESS (If rural, give location): Benedum St

3. NAME OF DECEASED (Type or Print): (First) Orion (Middle) Wesley (Last) Hess
4. DATE OF DEATH: (Month) Oct (Day) 22 (Year) 1949
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Dec 26-1872
9. AGE last birthday: 76 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kansas or Ohio
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: John D Hess
14. MOTHER'S MAIDEN NAME: Lydia Hess
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Mary S Hess - Union Bridge

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage

331 Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-20, 1949, to 10-22, 1949, that I last saw the deceased alive on 10-22-, 1949, and that death occurred at 10 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): T. H. Legg M.D. — ADDRESS: Union Bridge — DATE SIGNED: 10-22-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Oct 25. 1949 — NAME OF CEMETERY OR CREMATORY: Keysville Cemetery — LOCATION (City, town, or county): Keysville — (State): Maryland

DATE REC'D BY LOCAL REG.: Oct 24/49 — REGISTRAR'S SIGNATURE: Leslie L. Repp

24. FUNERAL DIRECTOR: D D Hartzler & Sons — ADDRESS: Union Bridge & New Windsor, Md

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 25 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09591

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (In this place): 1yr.11mos.13days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 17
STREET ADDRESS (If rural, give location): 1608 Madison Ave.,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
MAMIE	CHRISTEEN	HIGHSMITH	Oct., 10 19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
Female	Negro	Married	Mar.14,1919	30 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Wilson N. Caroline	

13. FATHER'S NAME: Loston Harris

14. MOTHER'S MAIDEN NAME: Lula Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		220-22-1316	Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Aug.1947
002 Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct.27, 1947, to Oct.10, 1949, that I last saw the deceased alive on Oct.10, 1949, and that death occurred at 10:20 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Reuben H. Braun, M. D.	Henryton, Maryland	10/10/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-18-49	Wilson, N.C.	Wilson N.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/10/49	Deputy Local Registrar	Wm. A. Jackson	916 Pennsylvania. AVE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
OCT 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09592

Reg. Dist. No. 7X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: CARROLL; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Sykesville; LENGTH OF STAY (in this place): 2 mos. 29 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: ; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore; STREET ADDRESS (If rural give location): 1721 South Charles Street

3. NAME OF DECEASED (Type or Print): (First) PETER (Middle) JAMES (Last) HORNEY

4. DATE OF DEATH: (Month) 10 (Day) 13 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1862 (Feb. 24)

9. AGE last birthday: 87 yrs.

If under 1 year: Months; Days

If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oysterman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Queen Anne County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W. Horney

14. MOTHER'S MAIDEN NAME: Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Sclerosis	indefinite
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic cardiovascular disease	indefinite
	(c)	

420.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile Psychosis, simple deterioration — indefinite

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/14, 1949, to 10/13, 1949, that I last saw the deceased alive on 10/13, 1949, and that death occurred at 12:05 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Henry C. Allread, M. D. ADDRESS: Sykesville, Maryland DATE SIGNED: 10/13/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF: 10/15/49 NAME OF CEMETERY OR CREMATORY: Cedar Hill LOCATION (City, town, or county) (State): Anne Arundel, Md.

DATE REC'D BY LOCAL REG. 10/14/49 REGISTRAR'S SIGNATURE: H. W. Hedrick

24. FUNERAL DIRECTOR: C. Howard Evans ADDRESS: 1400 S. Charles St. Balto. 30, Md.

MARYLAND STATE DEPARTMENT OF HEALTH Bc 09593

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton | LENGTH OF STAY (In this place) 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton, State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 2
STREET ADDRESS (If rural, give location) 1309 N. Calvert Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	Southey	Johns	Oct.	16,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
male	Negro	Sep.	March 26, 1887	62 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor		Burrowsville, Virgina	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Williams Johns	Louise Harves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		231-09-0877	Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Mar. 15, 1949
002 Antecedent cause(s)		
131 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 28, 1949, to Oct. 16, 1949, that I last saw the deceased alive on Oct. 16, 1949, and that death occurred at 8:30 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Julian H. Braun, M. D. ADDRESS Henryton, Maryland DATE SIGNED 10/16/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 18, '49	Gravel Hill Bapt. Church	Cabin Point, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/16/49	Deputy Local	John Elliott by Thurman Elliott, asst.	Claremont, Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 19 1949
BUREAU T. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

BC 09594

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (In this place): 4mos.18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 23
STREET ADDRESS (If rural, give location): 1411 Lemmon St.,

3. NAME OF DECEASED (Type or Print): (First) MABEL (Middle) (Last) JOHNSON

4. DATE OF DEATH: (Month) Oct., (Day) 30 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Dec. 1, 1929

9. AGE last birthday: 19 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Frank Johnson

14. MOTHER'S MAIDEN NAME: Florence L. Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-24-0652

17. INFORMANT: Mrs. Florence Johnson(Mother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	April, 1949
002 Antecedent cause(s)		
138 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 6, 1949, to Oct., 30, 1949, that I last saw the deceased alive on Oct., 30, 1949, and that death occurred at 7:15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Offerman, M.D. — ADDRESS: Henryton, Maryland — DATE SIGNED: 10/30/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Nov 3 1949 — NAME OF CEMETERY OR CREMATORY: Mt Calvary — LOCATION (City, town, or county) (State): Brooklyn Md.

DATE REC'D BY LOCAL REG. 10/30/49 — REGISTRAR'S SIGNATURE: Albert R. Saunders — Deputy Local

24. FUNERAL DIRECTOR: Elroy O Wilson — ADDRESS: 1000 Brantley ave

RECEIVED
NOV 2 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH BC 09595

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 3 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore-1
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 117 N. Eutaw Street.

3. NAME OF DECEASED (Type or Print)	(First) OLIVER	(Middle)	(Last) KEITH	4. DATE OF DEATH	(Month) October (Day) 23 (Year) 1949
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Sep.	8. DATE OF BIRTH Dec. 25, 1915	9. AGE last birthday 33 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Toccoa, Georgia	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Oliver Keith			14. MOTHER'S MAIDEN NAME Phyllis Letghetga		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. ---		17. INFORMANT Deceased		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Unknown

576 Antecedent cause(s)

129 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Peritonitis(Etiology undetermined) — March, 1949

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 21, 1949, to Oct. 23, 1949, that I last saw the deceased alive on Oct. 23, 1949, and that death occurred at 7 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.	Henryton, Md.	10-23-49

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE 10/28/49	NAME OF CEMETERY OR CREMATORY Toccoa, Ga.	LOCATION (City, town, or county) (State) Stephen Co.
DATE REC'D BY LOCAL REG. 10-23-49	REGISTRAR'S SIGNATURE Albert R. Swankhaus Deputy Local	24. FUNERAL DIRECTOR James G. Hayes	ADDRESS 638 N. Gilmore St. Balto., Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

09596

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester; LENGTH OF STAY (in this place) 10 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester; STREET ADDRESS (If rural, give location) Jark St.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) J. (Last) Kelley

4. DATE OF DEATH: (Month) Oct. (Day) 29 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1878

9. AGE last birthday: 71 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: retired

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Fransis De Marco

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Arteriosclerotic Heart Disease	4 yrs
420.0 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) ? Hypertension	5 yrs ?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 13, 1947, to Sept, 1949, that I last saw the deceased alive on Sept 30, 1949, and that death occurred at 5:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. H. Foard M.D. Manchester, Md Nov 1-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial; DATE 11-2-49; NAME OF CEMETERY OR CREMATORY: St. Bartholomew; LOCATION (City, town, or county): Manchester; (State): Md.

DATE REC'D BY LOCAL REG. Nov. 1 49

REGISTRAR'S SIGNATURE: Mrs. H. P. L. Benner

24. FUNERAL DIRECTOR: Jacob Winkler Sons ADDRESS: Manchester Md

RECEIVED

Evidence for addition of #21 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

BC 09597

CERTIFICATE OF DEATH

Reg. Dist. No. 74

FILM No. G 122 NOV 23 1949

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville; LENGTH OF STAY (in this place) 13 years 4 m; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield St. H.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Baltimore; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural, give location) Deep Wood Av 4012

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Elizabeth	X	Kunkel	Oct.	15	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
fem	wh.		Oct. 3. 1876	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Seamstress		?	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Kunkel	Julia Bucher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
			Sister mrs J. Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Metastatic carcinoma of r. breast (Underlying Cause)	5 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis	10 years
(c) Fracture of r. humerus	Sept. 22 49
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Dementia Praecox paran. type	28 years

170 186a

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY S.S. Hospital	(CITY OR TOWN) Sykesville	(COUNTY) Md.	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) 9/22/49 m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? Acc. fall in bath tub		(11/22/49 O.S.)

22. I hereby certify that I attended the deceased from Oct., 1947, to Oct 15., 1949, that I last saw the deceased alive on Oct 15., 1949, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Elizabeth A. Winiary	Springfield St H. Sykesville	Oct. 15, 49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	10/19/49	OAK LAWN CEMETERY	BALTIMORE, MD.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
10/17/49	A. W. Hedgecock	HENRY SANDER & SONS, INC.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Evidence for change of birth date & age is on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09598

FILM No. G 122 NOV 22 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH · COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Day P.O. — LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Day P.O.
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Sylvester	Lewis	Oct. 27, 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married	Feb. 8, 1884	64 65 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor	Building	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Sylvester P. Lewis	Rhoda C. Fleming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	218-14-9215	Elizabeth J. Lewis, Woodbine, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Secondary Anemia	4 wks.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Repeated Hemorrhages from Colon due to	4 wks.
(c) Carcenomatosis due to	4 mo.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcenoma of Pancreas	Over 8 mo.

157
46g

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Feb. 23, 1949	Carcenoma of Pancreas	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan. 1949, 19..., to Oct. 27, 19 49, that I last saw the deceased alive on 10/26/49, 19..., and that death occurred at 7 30 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. Stanley Grabill	M.D.	Mt. Airy, Maryland	Oct. 27, 1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-29-49	Morgan Chapel	Day, P.O. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct 31	Edna M. Hewitt	C. A. Keen	Sykesville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 3 1919
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09599

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gist — LENGTH OF STAY (in this place): 31 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gist
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location): Rural--Sykesville

3. NAME OF DECEASED (Type or Print)	(First) WELTHIE	(Middle) IRENE	(Last) LINDSAY	4. DATE OF DEATH	(Month) Oct. (Day) 9, (Year) 1949
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: 3-5-1899	9. AGE last birthday: 50 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY: U.S.		
13. FATHER'S NAME: William T. Gibson	14. MOTHER'S MAIDEN NAME: Delilah I. Miller				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT: Frank O. Lindsay, Sykesville, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) cerebral hemorrhage	48 hrs.
Antecedent cause(s)	(b) hypertensive cardiovascular	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) disease	?

443
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-7, 1949, to 10-9, 1949, that I last saw the deceased alive on 10-9, 1949, and that death occurred at 7:40 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[signature]	M.D.	Sykesville P.O	10/9/49

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL	DATE: 10-12-1949	NAME OF CEMETERY OR CREMATORY: Harmony Grove	LOCATION (City, town, or county) (State): Gist, Carroll Co. Md.
DATE REC'D BY LOCAL REG.: Oct 11, 49	REGISTRAR'S SIGNATURE: Edna M. Hewitt	24. FUNERAL DIRECTOR: C. M. Waltz, Winfield, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09600

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Baltimore Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 8mos. 23 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 1651 N. Fulton Ave/.

3. NAME OF DECEASED (Type or Print) (First) EDNA (Middle) (Last) LUNN			4. DATE OF DEATH (Month) Oct., (Day) 24 (Year) 1949		
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct., 12, 1907	9. AGE last birthday 42 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Dolington, S. Carolina		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Eddie Pauley			14. MOTHER'S MAIDEN NAME Lilly Pauley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Deceasec		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Nov., 1948

002 Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1, 1949, to Oct., 24, 1949, that I last saw the deceased alive on Oct., 24, 1949, and that death occurred at 9:15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.	Henryton, Md.	10/24/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Oct. 28, 1949	NAME OF CEMETERY OR CREMATORY Arbutus Cem.	LOCATION (City, town, or county) (State) Arbutus, Md.
DATE REC'D BY LOCAL REG. 10/24/49	REGISTRAR'S SIGNATURE Albert Swankham	24. FUNERAL DIRECTOR Mrs Kate R. Williams	ADDRESS

Deputy Local 322 N Schoolen St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 29 1949
BUREAU M. S.

09601

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 80

M

I

T

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor Rural
LENGTH OF STAY (in this place) 13 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor Rural
STREET ADDRESS (If rural give location) Springdale

3. NAME OF DECEASED (Type or Print) (First) Hall (Middle) McCauley (Last) Martin
4. DATE OF DEATH (Month) Oct (Day) 3 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Jan 26. 1899
9. AGE last birthday 50 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Carroll County - Md
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Charles Thomas Martin
14. MOTHER'S MAIDEN NAME Sadie Hall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-10-3481
17. INFORMANT Mrs L Pauline Martin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary Occlusion

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to Oct 3, 1949, that I last saw the deceased alive on Sept 30, 1949, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE T H Legg MD (Degree or title) ADDRESS Union Bridge DATE SIGNED 10-3-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 6-1949
NAME OF CEMETERY OR CREMATORY Lutheran Cemetery
LOCATION (City, town, or county) Uniontown (State) Maryland
DATE REC'D BY LOCAL REG. Oct 5/49
REGISTRAR'S SIGNATURE Emma S Bendert
24. FUNERAL DIRECTOR D D Hartzler & Sons ADDRESS New Windsor & Union Bridge - Md

RECEIVED
OCT 7 1949
BUREAU V. S.

09602

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

BC

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 27 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 1916 Patterson Park Ave

3. NAME OF DECEASED (Type or Print) (First) Ida (Middle) May (Last) Mitchell

4. DATE OF DEATH (Month) Oct (Day) 30 (Year) 1949

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Nov 5th 1882
9. AGE last birthday 66 yrs. If under 1 year Months 10 Days 25 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Covert
14. MOTHER'S MAIDEN NAME Martha Coe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	3 da
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Genl. Arterio Sclerosis	10 yrs
	(c)	

331
83a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 31, 1922 to Oct 30, 1949, that I last saw the deceased alive on Oct 30, 1949, and that death occurred at 4-20 m., from the causes and on the date stated above.

SIGNATURE W. F. Martin M.D. (Degree or title) ADDRESS Sykesville Md DATE SIGNED Oct 30-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov 3 1949
NAME OF CEMETERY OR CREMATORY Graceland Memorial Park
LOCATION (City, town, or county) Wilmington Del (State)

DATE REC'D BY LOCAL REG. 10-31-49
REGISTRAR'S SIGNATURE C. Harry Weir
24. FUNERAL DIRECTOR John C. Moran ADDRESS 3000 E. Baltimore St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
NOV 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09603

Reg. Dist. No. 79

1. PLACE OF DEATH:

County: Carroll

City or town: Detour - rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Detour - rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Florence Calvin Myers

3. (b) Social Security Number: —

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Anna Deberry Myers

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): January 2, 1875

8. AGE: Years: 74 Months: 9 Days: 3 If less than one day: hrs. min.

9. Birthplace: Silver Run, Carroll Co., Md.
(Town, county, and state)

10. Usual occupation: Farmer - retired

11. Industry or business

FATHER
12. Name: Rufus Myers
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Gouker
15. Birthplace: Maryland

16. Informant: Mrs. Anna Myers
Address: Detour, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct. 8, 1949
(month) (day) (year)

Cemetery or crematory: Keysville Cemetery

Location: Keysville, Md.

18. Funeral director: M. L. Creager & Son

Address: Thurmont, Md.

19. 10/6 1949 Fanny M. Powell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 5 1949, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1948, to Oct 5 1949 and that I last saw him alive on Oct 4 - 1949

Immediate cause of death: Chronic Myocarditis

Due to: Infection from Suppurative Appendicitis

Due to:

Other conditions:

550.0
121
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M.D.
M. D. or other

Address: Union Bridge Date signed: 10-5-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
OCT 10 1949
BUREAU V. A.

09604

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: CARROLL — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (in this place): 10 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 51 Gorman Avenue

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Otto		OBST	10	27	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	divorced	July 12, 1888	62 61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	-	German-Baltimore, Md.	[illegible]

13. FATHER'S NAME: Joseph Obst
14. MOTHER'S MAIDEN NAME: Amelia ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	-	Springfield State Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute myocarditis	a few minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — 422.2 93d	(b) Chronic myocarditis with myocardial degeneration	about 2 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: psychosis with cerebral arteriosclerosis — about 2 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
-	-	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
-	-	-		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ — Not While At work ☐	HOW DID INJURY OCCUR?
-			m.		-

22. I hereby certify that I attended the deceased from 12-17, 1948, to 10-27, 1949, that I last saw the deceased alive on 10-26-49, and that death occurred at 5:25 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
M. Virginia Beyer	M.D.	Sykesville, Md.	10-27-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 29, 1949	Woodlawn Cemetery	Woodlawn, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/28/49	[signature]	Wallis Lamoreau	4510 Liberty Heights Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

09605

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 81

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge | LENGTH OF STAY (in this place) 5 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
STREET ADDRESS (If rural give location) Main St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Harry	Cover	Reese	Oct	9	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	July 23 - 1877	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired farmer		Tiffin Ohio	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lewis J Reese	Hannah M Cover

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	none	Mrs Carrie B Reese

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Thrombosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

#422.1 93d (c) arteriosclerotic Cardio Vascular Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from July 1, 1948, to oct 9, 1949, that I last saw the deceased alive on oct 8, 1949, and that death occurred at 4 30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Merritt E. Robertson		New Windsor, Md	

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 12 - 1949	Pipe Creek	Cemetery Uniontown road	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct 10, 1949	Leslie L. Repp	D D Hahn & Sons	Union Bridge & New Windsor, Md

RECEIVED
OCT 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09606

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 2588 Edmondson Ave

3. NAME OF DECEASED (Type or Print) (First) FRANKLIN (Middle) G. (Last) RICHARDS

4. DATE OF DEATH (Month) (Day) (Year) Oct. 17. 1949

5. SEX M

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Apr. 8-1864

9. AGE last birthday 85 yrs. If under 1 year Months 00 Days 11 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob Richards

14. MOTHER'S MAIDEN NAME Elizabeth Buchman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. no

17. INFORMANT Mrs. Thomas Yockel 2588 Edmondson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	10 yrs
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Epilepsy	22 yrs
93d	(c) Genl. Arterio Sclerosis	20 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 14, 1929, to Oct 17, 1949, that I last saw the deceased alive on Oct 17, 1949, and that death occurred at 12 noon from the causes and on the date stated above.

SIGNATURE M. F. Martin M.D. (Degree or title) ADDRESS Sykesville Md DATE SIGNED Oct 17-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 10/20/49

NAME OF CEMETERY OR CREMATORY St. Mary's Cem.

LOCATION (City, town, or county) Hampden, Balto. (State) Md.

DATE REC'D BY LOCAL REG. 10/18/49

REGISTRAR'S SIGNATURE R.W. Hedrick

24. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

09607

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Cottonwood MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 33 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. #3

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) R.D. #3

3. NAME OF DECEASED (Type or Print) (First) Claude (Middle) Eugene (Last) Riffle
4. DATE OF DEATH (Month) Oct. (Day) 29 (Year) 1949
5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Sept 25 - 1882
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Bit.
10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.
11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Augustus Riffle
14. MOTHER'S MAIDEN NAME Sarah Jane Sheeley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-05-4116
17. INFORMANT Clara E. Riffle

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
974 Immediate cause	(a) Strangulation by hanging	—
164a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Some mental derangement	Several years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home (CITY OR TOWN) Westminster (COUNTY) Carroll (STATE) Md
TIME OF INJURY (Month) Oct. (Day) 29 (Year) 1949 (Hour) 6:45 A m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Hanged self

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE James T. Marsh, (Degree or title) Deputy Medical Examiner
ADDRESS Westminster Md
DATE SIGNED Oct 29, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 1 - 1949
NAME OF CEMETERY OR CREMATORY Kriders Cem.
LOCATION (City, town, or county) Westminster (State) Md.
DATE REC'D BY LOCAL REG. 10/30/49
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR H Bankard Hon
ADDRESS Westminster, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 1 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09608

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead — LENGTH OF STAY (in this place) 1 wk
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead - Rural
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	LEROY	RILL	October	16	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	SINGLE	Oct. 3, 1949	yrs.		13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Irvin G Rill
14. MOTHER'S MAIDEN NAME: Mary Bortner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Irvin G Rill.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congenital Atelectasis — 3 days

762.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

1610 (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	m.	INJURY OCCURRED While at Work ☐	Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 16, 1949, to Oct. 16, 1949, that I last saw the deceased alive on Oct. 16, 1949 and that death occurred at 6:00 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Maurice C Porterfield	M.D.	Hampstead, Md	10-16-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 17/49	Hampstead	Carroll Co	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 17, 1949	John S. Hughes, Jr.	Edw. C. Tipton	Hampstead Md

RECEIVED
OCT 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH BC

09609

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 21 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) W Mary (Middle) Schloer (Last)
4. DATE OF DEATH (Month) Oct (Day) 30 (Year) 1949
5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Jan 9-1904
9. AGE last birthday 45 yrs. If under 1 year Months 9 Days 21 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Dyendex
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph R Schloer
14. MOTHER'S MAIDEN NAME Katie Wetch
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT Joseph R Schloer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Lobar Pneumonia	1 wk
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Epilepsy	31 yrs
	(c)	

490
108

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1st, 1941, to Oct 30, 1949, that I last saw the deceased alive on Oct 30, 1949, and that death occurred at 9-30 m. from the causes and on the date stated above.

SIGNATURE J W Martin MD (Degree or title) ADDRESS Sykesville Md DATE SIGNED Oct 30-49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF NOV. 2 1949
NAME OF CEMETERY OR CREMATORY HOLY REDEEMER
LOCATION (City, town, or county) (State) 7400 BELAIR RD BALTO. MD
DATE REC'D BY LOCAL REG. 10/31/49
REGISTRAR'S SIGNATURE A. W. Hefrich
24. FUNERAL DIRECTOR DIPPEL BROTHERS ADDRESS 7110 BELAIR RD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

09610

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll Co | STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster | LENGTH OF STAY (In this place) 5-8 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md | COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 39 E. Green St.

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) CHRISTOPHER (Last) SEBOUR
4. DATE OF DEATH: (Month) October (Day) 11 (Year) 1949

5. SEX: M. | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: Aug 17th 1878 | 9. AGE last birthday: 71 yrs. | If under 1 year: Months / Days 24 | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Gas & Electric Co. | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Frederick Co | 12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: John Sebour | 14. MOTHER'S MAIDEN NAME: Julia Ann Utz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 212-05-3452 | 17. INFORMANT: Wm Sebour Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Artery disease

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T. Mowell	Deputy Medical Examiner	Westminster Md	Oct. 11-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct 13th 1949	Mount Union	Emmitsburg Md

DATE REC'D BY LOCAL REG. 10/13/49 | REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: E. Bankard & Son | ADDRESS: Westminster Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
OCT 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09611

CERTIFICATE OF DEATH

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place): 1yr. 3mos. 4days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
RICHARD	LEROY	SEWELL	Oct.	6,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	Negro	Single	7-2-1929	20 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rockville, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank E. Sewell
14. MOTHER'S MAIDEN NAME: Helen (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	April, 1946 10
002 Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 2, 1948, to Oct. 6, 1949, that I last saw the deceased alive on Oct. 6, 1949, and that death occurred at 12:15 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben W. Swan, M.D.		Henryton, Maryland	10/6/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 8	Rockville Mem	Montgomery Co	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/6/49	Albert R. Counihan Deputy Local	Robert L. Snouffer	Rockville Md

RECEIVED
OCT 12 1949
BUREAU V. S.

Evidence for change in #5 shown on:

FILM No. G 122 NOV 28 1949

09612

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY: CARROLL — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville - Rural
LENGTH OF STAY (in this place): 2 months, 29 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 415 Cumberland Street ✓

3. NAME OF DECEASED (Type or Print): (First) ROBERT (Middle) (Last) SHOWALTER
4. DATE OF DEATH: (Month) 10 (Day) 11 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 2/15/07
9. AGE last birthday: 42 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Contracting
11. BIRTHPLACE (State or foreign country): Frederick County, Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Showalter
14. MOTHER'S MAIDEN NAME: Annie Dodson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bronchopneumonia and meningitis resulting from	2-3 days
Antecedent cause(s)	(b) Mediastinitis due to perforation of oesophagus by dental plate	? 1-2 wks.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) General paresis (and therapeutic malaria)	2 mos. (known)

025
3rd

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/12, 1949, to 10/11, 1949, that I last saw the deceased alive on 10/11, 1949, and that death occurred at 7:25 A m., from the causes and on the date stated above.

SIGNATURE: Joseph H. Marshall, (Degree or title) M. D. ADDRESS: Sykesville, Maryland DATE SIGNED: 10/11/49

23. BURIAL / CREMATION / REMOVAL (Specify): Burial
DATE: Oct. 12, 1949
NAME OF CEMETERY OR CREMATORY: Springfield Hosp. Cem.
LOCATION (City, town, or county) (State): Sykesville Md.

DATE REC'D BY LOCAL REG.: Oct. 11 1949
REGISTRAR'S SIGNATURE: C. Haney Heer
24. FUNERAL DIRECTOR: C.H. Heer ADDRESS: Sykesville Md.

RECEIVED
OCT 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09613

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Carroll
County.....
City or town Westminister Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ida Mae Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife George Smith (Deceased) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 11 - 1883

8. AGE: Years 66 | Months 2 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace Millers Carroll Co, Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Barber
13. Birthplace Maryland

MOTHER 14. Maiden name Leah Miller
15. Birthplace Penna

16. Informant Harry D. Smith
Address Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-5-49 (month) (day) (year)

Cemetery or crematory Cemetery
Location Black Rock, Penna.

18. Funeral director Jacob Weaks Sons
Address Manchester Md.

19. 10-3-1945 (Date rec'd by registrar) F. Chronister Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1949, at 5:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1947 to Oct 1949 and that I last saw h.er alive on Oct 2 1949

Immediate cause of death	DURATION
Respiratory failure	
Due to Carcinoma right breast	12 years
Due to with metastatic spread at lung - liver and abdominal viscera	
Other conditions and Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations
170
50
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. H. Froard M.D
M. D. or other
Address Manchester, Md Date signed Oct 2-49

RECEIVED
OCT 5 1943
BUREAU V. S.

09614

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 1mo. 3days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 1,
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital	STREET ADDRESS (If rural, give location): 1127 Park Avenue

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) (Last) SQUIRRELL

4. DATE OF DEATH: (Month) Oct., (Day) 26 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 31, 1906

9. AGE last birthday: 43 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dry Cleaner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cockesville, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Squirrell

14. MOTHER'S MAIDEN NAME: Martha Tucker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: Lost

17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Jan., 1944
002 Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 23, 1949, to Oct., 26, 1949, that I last saw the deceased alive on Oct., 26, 1949, and that death occurred at 6. A. m., from the causes and on the date stated above.

SIGNATURE: Reuben Hoffman, M.D. (Degree or title) — ADDRESS: Henryton, Maryland — DATE SIGNED: 10/26/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Oct. 29, '49 — NAME OF CEMETERY OR CREMATORY: Mt. Aubrun — LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG.: 10/26/49 — REGISTRAR'S SIGNATURE: Albert R. Swankhaus — 24. FUNERAL DIRECTOR: Mrs. Geo. H. Holland, 1631 - Druid Hill Ave. Balto. Md. — ADDRESS:

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

ED
2 1949
REAU V. B.

09615

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 77

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead | LENGTH OF STAY (In this place) 10 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) SAMUEL (Middle) C (Last) STANSFIELD

4. DATE OF DEATH: (Month) Oct (Day) 24 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: Feb 28 1879

9. AGE last birthday: 70 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Oil Distr.

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin L Stansfield

14. MOTHER'S MAIDEN NAME: Elizabeth A Brosseau

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 245-14-1456

17. INFORMANT: Morris Stansfield

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Carcinomatosis — Interval Between Onset and Death: ?

177 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

51b (b) Primary Carcinoma Prostate Gland — 2 yr

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12-17-48

19b. MAJOR FINDINGS OF OPERATION: Carcinoma Prostate Gland

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 12, 1949, to Oct 24, 1949 that I last saw the deceased alive on Oct 24, 1949, and that death occurred at 4 25 A m., from the causes and on the date stated above.

SIGNATURE Joseph E Burke (Degree or title) MD — ADDRESS Hampstead Md — DATE SIGNED 10-24-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 10-26-49 — NAME OF CEMETERY OR CREMATORY Wesley — LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REG. Oct 25, 1949 — REGISTRAR'S SIGNATURE John S. Hughes Jr. — 24. FUNERAL DIRECTOR Edward Gipton — ADDRESS Hampstead Md

VS. A15

RECEIVED
OCT 27 1949
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09616

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Westminster — LENGTH OF STAY (in this place): 3 1/2 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Carroll County Home

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - near Silver Run
STREET ADDRESS (If rural, give location): Westminster. R.D.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): JERMIAH - STUDY

4. DATE OF DEATH (Month) (Day) (Year): Oct. 22 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan. 1-1879
9. AGE last birthday: 70 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day Laborer.
10b. KIND OF BUSINESS OR INDUSTRY: Laborer
11. BIRTHPLACE (State or foreign country): Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Emanuel Study
14. MOTHER'S MAIDEN NAME: Sarah Koontz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service): —
16. SOCIAL SECURITY No.: None.
17. INFORMANT AND ADDRESS: Paul L. Study, Westminster, Md. R.D.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio vascular disease — Cardiac decompensation — Years

422.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: No
19b. MAJOR FINDINGS OF OPERATION: No
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): No — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-2-, 1949 to 10-22, 1949, that I last saw the deceased alive on 10-, 1949, and that death occurred at 4 P m., from the causes and on the date stated above.

SIGNATURE: N. C. Stone M D (Degree or title) — ADDRESS: Westminster — DATE SIGNED: 10-22-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 10/24/49
NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
LOCATION (City, town, or county) (State): Silver Run, Carroll Co. Md.

DATE REC'D BY LOCAL REG.: 10/24/49
REGISTRAR'S SIGNATURE: [signature]
24. FUNERAL DIRECTOR: J. W. Little & Son, Leutestown PA — ADDRESS: Per R. A. Little

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH BC 09617

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 10 mos. 17 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (Cherry Hill)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 623 Round View Road

3. NAME OF DECEASED (Type or Print)	(First) JANIE	(Middle) LEE	(Last) TERRY	4. DATE OF DEATH	(Month) Oct., (Day) 27 (Year) 1949
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 19, 1938	9. AGE last birthday 11 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scholar	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Winston Salem, N. Carolina	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William Terry		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Judith Brown (Foster Mother)			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Aug., 1948
002 Antecedent cause(s)		
136 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 10, 1949 to Oct. 27, 1949, that I last saw the deceased alive on Oct., 27, 1949, and that death occurred at 3:45 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Maryland	10/27/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Oct. 31, 1949	NAME OF CEMETERY OR CREMATORY Florence Cem.	LOCATION (City, town, or county) (State) Florence, S. Carolina
DATE REC'D BY LOCAL REG. 10/27/49	REGISTRAR'S SIGNATURE Albert R Swankham	24. FUNERAL DIRECTOR Elroy O Wilson	ADDRESS

Deputy Local 1000 Brantley a.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 2 1959
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH BC 09618

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 10 mos. 20 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore-31
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State San.	STREET ADDRESS (If rural, give location) 1814 Orleans Street

3. NAME OF DECEASED (Type or Print)	(First) JASPER	(Middle)	(Last) TYLER	4. DATE OF DEATH	(Month) Oct. (Day) 21 (Year) 1949
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Sep.	8. DATE OF BIRTH Feb. 15, 1915	9. AGE last birthday 34 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Charlotte N. Carolina	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Muluus Tyler		14. MOTHER'S MAIDEN NAME Maggie Williams			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 218-01-1640	17. INFORMANT Deceased			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	August 16, 1948
002 Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 9, 1948, to Oct. 21, 1949, that I last saw the deceased alive on Oct. 21, 1949, and that death occurred at 4:25 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.	Henryton, Md.	10-21-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 26-49	Mt Calvary Cem	Brooklyn A. A. Co Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-21-49	Albert R. Swarkhams Deputy Local	Elroy O. Wilson	1000 Brantly Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 25 1949
BUREAU V. S.

78 W. Main

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09619

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH · COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Uniontown R.D. LENGTH OF STAY (in this place) 7 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Mrs. Mary	(Middle) A	(Last) Wantz	4. DATE OF DEATH (Month) October	(Day) 15	(Year) 1949
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct.30,1866	9. AGE last birthday 82 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Joseph Helwig		14. MOTHER'S MAIDEN NAME Catherine Zepp			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. No	17. INFORMANT Mrs.Walter Haines			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) ventricular fibrillation	2 weeks
420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) arteriosclerotic heart disease	6 or 7 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2, 1942, to Oct 15, 1949, that I last saw the deceased alive on Oct 12, 1949, and that death occurred at 2 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
E Reese Wilkens	6 Carroll St	Westminster Md	10/15/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 10/16/49	NAME OF CEMETERY OR CREMATORY St Matthews	LOCATION (City, town, or county) Pleasant Valley	(State) Md
DATE REC'D BY LOCAL REG. Oct. 16/49	REGISTRAR'S SIGNATURE Margaret R. Englar	24. FUNERAL DIRECTOR C.O.FUSS & SON	ADDRESS Taneytown, Md.	

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Wilkinson

M

I

T

RECEIVED
OCT 21 1949
BUREAU P. R.

MARYLAND STATE DEPARTMENT OF HEALTH Bc 09620

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 1mo. 28 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 1,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 23 N. Poppleton St.,

3. NAME OF DECEASED (Type or Print)	(First) WILLIAM	(Middle)	(Last) WORDLAW	4. DATE OF DEATH (Month) Oct., (Day) 10 (Year) 1949
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH July 4, 1903	9. AGE last birthday 46 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Troy, S. Caroline	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Wordlaw		14. MOTHER'S MAIDEN NAME Amanda Hurst		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 705-05-8378	17. INFORMANT Deceased		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — 3/1/49

002 Antecedent cause(s)

130 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 12, 1949, to Oct., 10, 1949 that I last saw the deceased alive on Oct. 10, 1949, and that death occurred at 8:45 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M. D.		Henryton, Maryland	10-10-49

23. BURIAL, CREMATION REMOVAL. (Specify) Burial	DATE 10-14-49	NAME OF CEMETERY OR CREMATORY Mt. Calvary	LOCATION (City, town, or county) G. Anne Co. (State) Md.
DATE REC'D BY LOCAL REG. 10/10/49	REGISTRAR'S SIGNATURE Albert R. Swanthan	24. FUNERAL DIRECTOR Mrs Katie R. William	ADDRESS 322 N. Schroeder St

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09621

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: CARROLL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WESTMINSTER
LENGTH OF STAY (in this place): LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 118 PENNSYLVANIA AVE

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WESTMINSTER
STREET ADDRESS (If rural, give location): 118 PENNSYLVANIA AVE.

3. NAME OF DECEASED (Type or Print): (First) WALTER (Middle) L. (Last) ZEPP

4. DATE OF DEATH: (Month) OCTOBER (Day) 10 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: AUG. 14, 1885

9. AGE last birthday: 64 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK

10b. KIND OF BUSINESS OR INDUSTRY: RETAIL MDSE.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY ZEPP

14. MOTHER'S MAIDEN NAME: ELIZABETH MYERLY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If year, give war or dates of service): —

16. SOCIAL SECURITY No.: 214-01-0497

17. INFORMANT AND ADDRESS: LAWRENCE ZEPP WESTMINSTER, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval Between Onset and Death: 1 hour

4200 Antecedent cause(s) (b) arteriosclerotic heart disease — about 1 year

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Jan 1, 1948, to Oct 10 1949, that I last saw the deceased alive on Oct 9, 1949, and that death occurred at 4 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) E Reese Wilkens, M.D. ADDRESS Westminster Md DATE SIGNED 10/10/49

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL
DATE: OCT. 12, 1949
NAME OF CEMETERY OR CREMATORY: KRIDER'S CEMETERY
LOCATION (City, town, or county): NR. WESTMINSTER (State) MD.

DATE REC'D BY LOCAL REG. 10/11/49

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: J. FRANCIS REESE ADDRESS: WESTMINSTER, MD.

RECEIVED
OCT 12 1949
BUREAU V. S.